	The Counseling Center of Wayne and Holmes Counties
	Request to Restrict Use & Disclosure of Health Information

SECTION A: Client to complete the following information.

NAME:_____ BIRTH DATE:_____

ADDRESS:_____

TELEPHONE:_____ DATE:_____

REQUEST:

I hereby request The Counseling Center to restrict the use and disclosure of the following information:

CLIENT/PARENT/GUARDIAN ACKNOWLEDGEMENT OF CONDITIONS OF RESTRICTION
(Client/Parent/Guardian to initial each condition.)

1. _____ I understand that The Counseling Center is not required to agree to this request for restriction.

2. _____ I understand that The Counseling Center may agree to only a part of the request for restriction, while denying agreement to the remaining request.

3. _____ I understand that if The Counseling Center agrees to the requested restriction (whether all or in part), then the restriction is in effect until one of the following events occurs:

    a. I agree to or request in writing that the restriction be terminated

    b. The Counseling Center notifies me in writing that it is terminating the agreement to restrict. If The Counseling Center terminates the agreement to restrict, then the termination is effective only with respect to information created or maintained after the date of the restriction

4. _____ I understand that my restricted health information may be disclosed to provide emergency treatment and that The Counseling Center will not further use or disclose my restricted health information for any other purpose.

5. _____ I understand that I still have a right to access my health information as allowed under applicable law.

Client Name _____ Case Number_____

cc: Medical Records

6. _____ I understand that my restricted health information may still be disclosed for public policy purposes as stated in The Counseling Center's privacy practices.

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

SECTION B: The Counseling Center to complete the following.

Request for restriction is: ☐ Accepted ☐ Denied

Comments:

_____ _____
Diane S. DeRue, MPA, LSW Date
Compliance and Privacy Officer

Client Name _____ Case Number_____
cc: Medical Records
DSD (01/03) (Rev. 04/04) 2 of 2
(QA 11/04)